

Date/Time	Inmate's Name:	D.O.B.: / /
4/20/06	57 Pichirich Mass being processed	
	07 16.5 x 10.5 inches mass today	
	Am I will be submit for excision	

EXHIBIT  
A-2



## Nursing Evaluation Tool:

## Dental Complaint

Facility: BBB	Patient Name: <u>Palmer</u> <u>Nelson</u>	
Inmate Number: <u>173297</u>	Date of Birth: <u>MM</u> <u>DD</u> <u>YYYY</u>	MI
Date of Report: <u>11</u> <u>23</u> <u>05</u>	Time Seen: <u>AM</u> / <u>PM</u>	Circle One

**Subjective:** Chief Complaint(s): Tooth Ache Right side of mouth

Onset: 23 days

History:

(Continue on back if necessary)

☐ Check Here if additional notes on back

Is the problem: ☒ New ☐ Chronic Problem related to: ☐ Recent trauma ☐ Recent dental work ☐ Other:  
 Injury sustained in altercation with custody staff, or other inmate: ☒ NO ☐ YES (Requires notification of correctional staff)  
 Dental Pain: Right: ☒ Upper Back ☐ Upper Front ☐ Lower Back Left: ☐ Upper Back ☐ Upper Front ☐ Lower Back  
☐ Lower Front  
 Type of Pain: ☒ Aching ☐ Throbbing ☐ Dull ☐ Sharp ☐ Constant ☐ Intermittent  
 Sensitive to Hot or Cold: ☐ No ☐ Hot ☐ Cold ☐ Sensitive to both Hot & Cold  
 Associated Symptoms: ☐ Sinus problems ☐ Difficulty chewing ☐ Earache ☐ Sore throat ☐ Other:  
 Pain Scale: (1-10) 4-5

**Objective:** Vital Signs: (If Indicated) T: 88 P: 88 RR: 22 B/P: 100 120 70/45

Visual evidence of tooth decay/fracture  
 Visual evidence of missing filling  
 Pain upon opening jaw widely

☐ No ☐ Yes  
☐ No ☐ Yes  
☐ No ☐ Yes

Visible external swelling  
 Swelling/redness/pus surrounding affected tooth:  
 Evidence of trauma/injury to jaw/face

☐ No ☒ Yes  
☐ No ☐ Yes  
☐ No ☐ Yes

☐ Additional Examination:

(Continue on back if necessary)

☐ Check Here if continued on back

**Assessment: (Referral Status)**

☐ Referral Not Required

☐ Referral Required due to the following: (Check all that apply)

☐ Fever ☐ Evidence of pus collection or swelling  
☐ Earache/sore throat/sinus problems ☐ Recent dental surgery/procedure  
☐ Pain upon opening mouth widely ☐ Significant injury/trauma to jaw

☐ Recurrent Complaint (More than 2 visits)

☐ Other:

(Describe)

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

**Plan:** Check All That Apply:

☒ For tooth pain; instruct patient to avoid hot/cold food; to chew on the opposite side of the tooth pain and to do salt water gargles PRN  
☐ Warm rinses PRN (Note: **DO NOT** apply warm compress to outside of face for dental abscess)  
☐ Cold Compress PRN for minor trauma  
☐ Instructions to return if condition worsens.  
☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)  
☐ Other:

(Describe)

☐ OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr Thomas - Dentist Date for referral: 11 23 05

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

X

Nurses Signature

Name:

Printed

Print Name: NELSON PALMER Date of Request: 11-21-05  
ID # 173247 Date of Birth: [REDACTED] Location: 11-22  
Nature of problem or request: TOOTH ACHE AND NEED TO HAVE IT  
PULLED AND TEETH CHECKED

*Michael Palmer*  
Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Time: \_\_\_\_\_ AM PM  
Allergies: \_\_\_\_\_

RECEIVED	
Date:	
Time:	
Receiving Nurse Initials	

(O)bjective (V/S): T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

**(P)lan:**

CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

HOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



## Nursing Evaluation Tool:

## General Sick Call

Facility: BBB	Patient Name: <u>Palmer Nelson</u>	MMDA
Inmate Number: <u>173247</u>	Date of Birth: <u>[REDACTED]</u>	MM DD YY
Date of Report: <u>11/14/05</u>	Time Seen: <u>0500</u> <u>AM</u> PM Circle One	MM DD YY

**Subjective:** Chief Complaint(s): "Knot on my back hurts" "Lipoma Back of Neck"

Onset: size of small kick ball

Brief History: 2000 Lump x 3 yrs SES  
(Continue on back if necessary)

☐ Check Here if additional notes on back

**Objective:** Vital Signs: (As Indicated) T: 97.4 P: 78 RR: 20 B/P: 140/80 204

Examination Findings: A+Ox3, Denies Resp Difficulty, HR 78 RRR  
(Continue on back if necessary)  
GI Complaints Ambulating w/ High Lipoma to  
Back of Cervical Spine area. In appearance it  
resembles a Buffalo Lump. Pain of 4 on Scale 1-10.

☐ Check Here if additional notes on back

**Assessment: (Referral Status) Preliminary Determination(s):** Alter in Comfort Rt

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: \_\_\_\_\_

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

**Plan:** Check All That Apply:

☐ Instructions to return if condition worsens.

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: \_\_\_\_\_

OTC Medications given ☐ NO ☐ YES (If Yes List): \_\_\_\_\_

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr. Siddiq Date for referral: 11/14/05

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): \_\_\_\_\_ Time: \_\_\_\_\_

x Martha Jackson (Signature) Name: CH. H. Jackson  
Nurses Signature Printed



## Nursing Evaluation Tool:

## General Sick Call

Facility: BBB	Patient Name: <u>Palmer Nelson</u>
Inmate Number: <u>173247</u>	Date of Birth: <u>MM DD YYYY</u>
Date of Report: <u>9/27/2008</u>	Time Seen: <u>5:45</u> <u>AM</u> PM Circle One

**Subjective:** Chief Complaint(s): my Neck giving me problems - been there for years but  
never hurt like this - vs. at work

Onset: \_\_\_\_\_

Brief History: \_\_\_\_\_  
 (Continue on back if necessary)

**Objective:** Vital Signs: (As Indicated) T: 97.8 P: 72 RR: 20 B/P: 100/70 at 196

Examination Findings: \_\_\_\_\_  
 (Continue on back if necessary)

**Assessment: (Referral Status) Preliminary Determination(s):** \_\_\_\_\_

☐ Referral **NOT REQUIRED**

☐ Referral **REQUIRED** due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: \_\_\_\_\_

**Comment:** You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

**Plan:** Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: \_\_\_\_\_

OTC Medications given ☐ NO ☐ YES (If Yes List): \_\_\_\_\_

Referral: ☐ NO ☐ YES (If Yes, Whom/Where): \_\_\_\_\_ Date for referral: MM/DD/YYYY

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): \_\_\_\_\_ Time: \_\_\_\_\_

X \_\_\_\_\_ Name: \_\_\_\_\_  
 Nurses Signature Printed



## Nursing Evaluation Tool:

General Sick Call

Facility: BBB	Patient Name: <u>Palmer Nelson</u>
Inmate Number: <u>173247</u>	Date of Birth: <u>MM/DD/YYYY</u>
Date of Report: <u>10/7/05</u>	Time Seen: <u>6:10</u> AM/PM Circle One

**Subjective:** Chief Complaint(s): Knot to back of neck. (hurting more)  
 Onset: approx 3 years pain set wave.

Brief History:  
 (Continue on back if necessary)

**Objective:** Vital Signs: (As Indicated) T: 98.4 P: 50 RR: 20 B/P: 110/80 | wt 196  
98%

Examination Findings:  
 (Continue on back if necessary)

**Assessment:** (Referral Status) Preliminary Determination(s):

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

**Plan:** Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where):

Date for referral: MM/DD/YYYY

Referral Type: ☐ Routine ☒ Urgent ☐ Emergent (if emergent who was contacted?):

Time

x L. Anderson Spr  
 Nurses Signature

Name:

Printed



PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST

Print Name: Nelson Palmer Date of Request: 10-7-04  
ID # 173247 Date of Birth: [REDACTED] Location: 11-22  
Nature of problem or request: \_\_\_\_\_

I Have a knot on my neck that  
is bothering me I need to get check out by the Dr.

Nelson Palmer  
Signature

DO NOT WRITE BELOW THIS LINE

Date: \_\_\_/\_\_\_/\_\_\_  
Time: \_\_\_ AM PM  
Allergies: \_\_\_\_\_

RECEIVED
Date: _____
Time: _____
Receiving Nurse Initials _____

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

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**PRISON  
HEALTH  
SERVICES  
INCORPORATED**

Print Name: NEKON PALMER Date of Request: 19 Jan. 05  
ID # 173247 Date of Birth: [REDACTED] Location: 1-16  
Nature of problem or request: Need some cream for my  
Face. My face is broken-out.

Nelson Palmer  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Time: \_\_\_\_\_ AM PM  
Allergies: \_\_\_\_\_

Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Receiving Nurse Initials \_\_\_\_\_

**(S)ubjective:**

## **(O)bjective**

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

**SIGNATURE AND TITLE**

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DEPARTMENT OF CORRECTIONS  
TRANSFER & RECEIVING SCREENING FORM

116

RECEIVED: Inmate/Health Record

Institution: Burlack  
Date: 7/18/05 Time: 0900 AM/PM  
RECEIVED FROM:  
Institution/Work Release Center/Free-World Hospital

RECEIVING MEDICAL STATUS

☒ Population☐ Infirmary☐ Isolation

RELEASED: Inmate/Health Record

Institution: KCF  
Date: 7-13-05 Time: \_\_\_\_\_ AM/PM  
RELEASE FROM:☐ Infirmary☐ Segregation☒ Population☐ Mental Health☐ Other

RELEASE TO:

☒ DOC☐ Infirmary☐ Mental Health☐ \_\_\_\_\_

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

PHYSICAL EXAMINATION

Date of last exam: 6-22-05

Chest X-Ray Date: \_\_\_\_\_ Result: \_\_\_\_\_

PPD Reading 6-24-05 0 mm

Classification: \_\_\_\_\_

Limitations: \_\_\_\_\_

LAB RESULTS - - LAST REPORT

CBC

Urinalysis

Date 6-22-05  
6-21-05

Normal

Abnormal

Wears Glasses/Contacts ☐Dental Prosthesis ☒Hearing Aide ☐Other Prosthesis ☐

YES

NO

☒☐☒☐☒

Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

Prolixin 10mg qhs x 90 d  
Benadryl 50mg po qhs x 90 d  
Selsun Shampoo TOP QD x 90 d (KOP)  
Hydrocortisone O. 50% TOP BID x 30 days

MEDICATIONS

X-RAY FILM

HEALTH RECORD

Released to: \_\_\_\_\_

☒ Sent w / inmate☐ Not sent w / inmate☐ Sent w / inmate☒ Not sent w / inmate☒ Sent w / inmate☐ Not sent w / inmate

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

MEDICATIONS

X-RAY FILM

HEALTH RECORD

CHART REVIEWED

☐ Received☐ Not Received☐ Received☐ Not Received☐ Received☐ Not Received☒ YES☐ NO

Received by: \_\_\_\_\_

Signature of Receiving Nurse

Date: 7/18/05 Time: 0900 AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: \_\_\_\_\_ LAST CLINIC: \_\_\_\_\_

FOLLOW-UP CARE NEEDED

☒ Medical☐ Dental☒ Mental Health

With Whom - - Location (Sending Nurse)

Date/Appt. Made w/Whom (Rec. Nurse)

7/18/05 DR. S. J. 1/16

(Noted from health record documentation)

HISTORY	Yes No	
	Yes	No
Drug Use	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Mental Illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Suicide Attempt	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Chronic Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

STATUS	Yes No	
	Yes	No
Special Diet	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Appearance	<input type="checkbox"/>	<input checked="" type="checkbox"/>

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)  
(Noted from inmate assessment)

SKIN	Yes No	
	Yes	No
Open Sores	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Lice	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Edema	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Warm & Dry	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cool & Moist	<input type="checkbox"/>	<input checked="" type="checkbox"/>

CONDITION	Yes No	
	Yes	No
Alert	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Oriented	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Uncooperative	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Depressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>

INTAKE

Sick Call Procedures Explained YesHeight 5'11"Weight 203Blood Pressure 130/80Temperature 98Pulse Resp 72/18

Other \_\_\_\_\_

Signature of Nurse Completing Assessment (Sending Nurse)

INMATE NAME (LAST, FIRST, MIDDLE)

Dalmer, Nelson

I-MD-70009

7-13-05  
Date

Signature of Intake Screening Nurse (Receiving Nurse)

DOC#

173247A

DOB

Race/Sex












































































































































































































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FAC.

K.C.F.

(White - Medical Test Kit)

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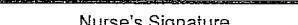

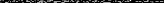

Facility Name: <u>Bullock Correctional Facility</u>											Month/Y		Charting: <u>03/06</u>																	
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Cogentin 2MG Tab 30.00																														
Take 1 tablet(s) by mouth at bedtime											<div style="text-align: center;">  </div>																			
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Facility Name:										Month/Ye.										Charting:									
<i>Bullock</i>																				<i>3/06</i>									
<i>Prolitin Dec. 25mg</i> <i>IM q 3 wks X-90 days</i>										<i>BP</i>										<i>at</i>									

Diagnosis	Nurse's Signature		Initial	Nurse's Signature		Initial	Documentation Codes
	<i>G. Thomas</i>		<i>AT</i>	<i>B. Smith</i>		<i>BP</i>	1. Discontinued Order
Allergies <i>NKA</i>							2. Refused
							3. Patient out of facility
							4. Charted in Error
Housing Unit:							5. Lock Down
Patient ID Number: <i>173247</i>							6. Self Administered
Patient Name:							7. Medication out of Stock
<i>Dalmar, Nelson</i>				Date of Birth:			8. Medication Held
							9. No Show
							10. Other

Facility Name: <u>Bullock</u>											Month/Ye. <u>2016</u>		Charting: <u>HOL</u>																		
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<u>Protixin Dec. 25mg</u> <u>1mg 3wks x 70 days</u>	<u>MD</u>																														
	Start Date: <u>1-3-06</u>										Prescriber: <u>Whately</u>																				
	Stop Date: <u>4-03-06</u>										RX #:																				
	Start Date:										Prescriber:																				
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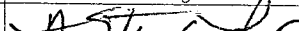


Diagnosis		Initial	Nurse's Signature	Initial	Documentation Codes
Allergies: 					
Housing Unit:					
Patient ID Number: 					
Patient Name: 					
			Date of Birth:		1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other



[illegible]

Facility Name: <u>BCCF A465</u>		Month/Yr		Charting: <u>01/06</u>																												
Pro Dec 25mg 1mg 3wks x90days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: <u>01/03/06</u>		Prescriber: <u>Whately</u>																														
Stop Date: <u>04/03/06</u>		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
Allergies <u>NKDA</u>  Housing Unit: Patient ID Number: <u>172 247</u> Patient Name: <u>Palmer, Nelson</u>	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes																											
			<u>Bennett</u>	<u>BP</u>	1. Discontinued Order																											
					2. Refused																											
					3. Patient out of facility																											
					4. Charted in Error																											
					5. Lock Down																											
					6. Self Administered																											
					7. Medication out of Stock																											
					8. Medication Held																											
					9. No Show																											
					10. Other																											
			Date of Birth:																													



Diagnosis	Nurse's Signature		Initial	Nurse's Signature		Initial	Documentation Codes
Allergies <b>NKDA</b>			<b>JS</b>	<b>LEISI KUOH</b>		<b>LK</b>	1 Discontinued Order
			<b>PN</b>			<b>LN</b>	2 Refused
							3 Patient out of facility
Housing Unit:							4 Charted in Error
Patient ID Number: <b>173249</b>							5 Lock Down
Patient Name: <b>Palmer Nelson</b>							6 Self Administered
							7 Medication out of Stock
							8 Medication Held
							9 No Show
							10 Other
				Date of Birth:			

Facility Name: Bullock Correctional Facility		Month/Y: 01/06		Charting: 01/06																											
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Cogentin 2MG Tab 30.00																															
Take 1 tablet(s) by mouth at bedtime		1700 <del>1100</del> <i>See New Order</i>																													
Start Date: 12-06-2005		Prescriber: Andrews MHM, John																													
Stop Date: 01-04-2006		RX #: 250947700																													
Fluphenazine Decanoate 25MG/ML Solution 1																															
Inject intramuscular 1cc every three weeks		<i>See Deconate Book</i>																													
Start Date: 10-06-2005		Prescriber: Whatley MHM, Robert																													
Stop Date: 01-03-2006		RX #: 250724142																													
Fluphenazine HCl 10MG Tab 30.00																															
Take 1 tablet(s) by mouth daily		1700 <del>1100</del> <i>See New Order</i>																													
Start Date: 10-06-2005		Prescriber: Whatley MHM, Robert																													
Stop Date: 01-03-2006		RX #: 250724150																													
Diphenhydramine HCl 50MG Cap 60.00																															
Take 1 capsule(s) by mouth twice daily		1100 <del>1700</del> <i>See New Order</i>																													
Start Date: 10-06-2005		Prescriber: Whatley MHM, Robert																													
Stop Date: 01-03-2006		RX #: 250724153																													
Prolixin Dec 25mg IM q 3 wks x 90 days																															
Start Date: 01/03/06		Prescriber: Whatley																													
Stop Date: 04/03/06		RX #:																													
Hour		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Start Date:		Prescriber:																													
Stop Date:		RX #:																													

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies: NKDA	<i>D. L. Smith</i>	DL	<i>Smith</i>	SS	1. Discontinued Order
Housing Unit: RTU (MHM)	<i>LEIGH KUOH</i>	LK	<i>Smith</i>	SS	2. Refused
Patient ID Number: 173247	<i>Blanca SP</i>	BL			3. Patient out of facility
Patient Name: Palmer, Nelson					4. Charted in Error
					5. Lock Down
					6. Self Administered
					7. Medication out of Stock
					8. Medication Held
					9. No Show
					10. Other



Facility Name: Buick Correctional Facility										Month/Year of Charting: 12/05																						
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Triamcinolone Acetonide 0.1% Cream 1																																
Use as directed																																

Facility Name: <u>Bullock</u>		Month/Yr: <u>12/05</u>		Charting: <u>12/05</u>																													
Prolixin Dec. 25mg IM q3wks x 90 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start Date: <u>10/05/05</u> Stop Date: <u>1/05/06</u>	Prescriber: <u>Whatley</u>		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start Date: Stop Date:	Prescriber:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start Date: Stop Date:	Prescriber:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start Date: Stop Date:	Prescriber:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start Date: Stop Date:	Prescriber:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start Date: Stop Date:	Prescriber:		RX #:																														
	Diagnosis Allergies Housing Unit: Patient ID Number: Patient Name:	Nurse's Signature <u>Palmer Nelson</u>	Initial <u>PN</u>	Nurse's Signature Initial	Documentation Codes 1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other																												



Facility Name: Buick Correctional Facility		Month/1	Charting: 11/05
Benzotropine Mesylate 2MG Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
Take 1 tablet(s) by mouth at bedtime	1700		
	Start Date: 09-12-2005	Prescriber: Whatley MHM, Robert	
	Stop Date: 12-10-2005	RX #: 250584179	
Fluphenazine Decanoate 25MG/ML Solution 1	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
Inject intramuscular 1cc every three weeks			
	Start Date: 10-06-2005	Prescriber: Whatley MHM, Robert	
	Stop Date: 01-03-2006	RX #: 250724142	
Fluphenazine HCl 10MG Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
Take 1 tablet(s) by mouth daily	1700		
	Start Date: 10-06-2005	Prescriber: Whatley MHM, Robert	
	Stop Date: 01-03-2006	RX #: 250724150	
Diphenhydramine HCl 50MG Cap 60.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
Take 1 capsule(s) by mouth twice daily	1100 1700		
	Start Date: 10-06-2005	Prescriber: Whatley MHM, Robert	
	Stop Date: 01-03-2006	RX #: 250724153	
Adril 80mg POTIO x1000s	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
	Start Date: 11/14/05	Prescriber: Dr Sidds	
	Stop Date: 11/24/05	RX #:	
	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
	Start Date:	Prescriber:	
	Stop Date:	RX #:	
Diagnosis	Nurse's Signature	Initial	Documentation Codes
Allergies NKDA	Blumner STD	SS	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
Housing Unit: RTU (MHM)			
Patient ID Number: 173247			
Patient Name: Palmer, Nelson			

Facility Name: <u>BCCF</u>		Month/Yr											Charting: <u>8-30-05</u>																		
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Prolitin Dec. 25mg IM Q3 wks X-90 days	1535 Q <span style="float: right;">M.</span>																														
	Start Date: <u>7-18-05</u>											Prescriber:																			
	Stop Date: <u>10-18-05</u>											RX #:																			
	Start Date:											Prescriber:																			
	Stop Date:											RX #:																			
	Start Date:											Prescriber:																			
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	Start Date:											Prescriber:																			
	Stop Date:											RX #:																			
	Start Date:											Prescriber:																			
	Stop Date:											RX #:																			

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
	<u>A. Thomas</u>	<u>AT</u>			1 Discontinued Order
Allergies					2 Refused
<u>NKA</u>					3 Patient out of facility
Housing Unit: <u>RT4</u>					4 Charted in Error
Patient ID Number: <u>173247</u>					5 Lock Down
Patient Name: <u>Palmer Nelson</u>					6 Self Administered
					7 Medication out of Stock
					8 Medication Held
					9 No Show
					10 Other
			Date of Birth:		



Facility Name: <u>BCCF</u>		Month/Yr: <u>10/05</u>															Charting: <u>10/05</u>															
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Prolixin Dec. 25mg IM Q 3 wks X-90 days		<div style="text-align: center;"> <u>R40</u>    <u>10/05/05</u> </div>																														
		Start Date: <u>7-18-05</u>															Prescriber:															
		Stop Date: <u>10-18-05</u>															RX #:															
Prolixin Dec. 25mg IM Q 3 wks X 90 days		<div style="text-align: center;"> <u>0730</u>    <u>28</u> </div>																														
		Start Date: <u>10/05/05</u>															Prescriber: <u>Whalley</u>															
		Stop Date: <u>1/05/06</u>															RX #:															
		Start Date:															Prescriber:															
		Stop Date:															RX #:															
		Start Date:															Prescriber:															
		Stop Date:															RX #:															
		Start Date:															Prescriber:															
		Stop Date:															RX #:															
		Start Date:															Prescriber:															
		Stop Date:															RX #:															

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies <u>NKA</u>	<u>A. Thomas</u>	<u>AT</u>	<u>[Signature]</u>	<u>JS</u>	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other
Housing Unit: <u>RT4</u>					
Patient ID Number: <u>173247</u>					
Patient Name: <u>Palmer Nelson</u>					
			Date of Birth:		



Facility Name: <u>Bullock Correctional Facility</u>		Month: <u>10/05</u>	Charting: <u>10/05</u>
Fluphenazine HCl 10MG Tab	30.00		
Take 1 tablet(s) by mouth daily			
Start Date: <u>07-20-2005</u> Stop Date: <u>10-17-2005</u>		Prescriber: <u>Sanders MHM, William</u> RX #: <u>250236731</u>	
Diphenhydramine HCl 50MG Cap	60.00		
Take 1 capsule(s) by mouth twice daily			
Start Date: <u>07-20-2005</u> Stop Date: <u>10-17-2005</u>		Prescriber: <u>Sanders MHM, William</u> RX #: <u>250236753</u>	
Bzotropine Mesylate 2MG Tab	30.00		
Take 1 tablet(s) by mouth at bedtime			
Start Date: <u>09-12-2005</u> Stop Date: <u>12-10-2005</u>		Prescriber: <u>Whatley MHM, Robert</u> RX #: <u>250584179</u>	
Prolixin 10mg po qday	X 90 days		
Start Date: <u>10/05/05</u> Stop Date: <u>1/05/06</u>		Prescriber: <u>Whatley</u> RX #:	
Benadryl 50mg T BID	X 90 days		
Start Date: <u>10/05/05</u> Stop Date: <u>1/05/06</u>		Prescriber: <u>Whatley</u> RX #:	
Prolixin Dec. 25mg IM	q 3wks X 90 days		
Start Date: <u>10/05/05</u> Stop Date: <u>1/05/06</u>		Prescriber: <u>Whatley</u> RX #:	
Diagnosis	Nurse's Signature: <u>E. Tyson LPN ET</u> Initial: <u>ET</u>		
Allergies	Nurse's Signature: <u>Esmerth L</u> Initial: <u>ES</u>		
Housing Unit:	Population	Date of Birth:	
Patient ID Number:	<u>173247</u>		
Patient Name:	<u>Palmer, Nelson</u>		

- Documentation Codes
- 1 Discontinued Order
  - 2 Refused
  - 3 Patient out of facility
  - 4 Charted in Error
  - 5 Lock Down
  - 6 Self Administered
  - 7 Medication out of Stock
  - 8 Medication Held
  - 9 No Show
  - 10 Other

Facility Name: <u>Bullscle</u>		Month/Day, Charting: <u>10-05</u>																														
Advil 500g POTID x 10 dy	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	0400	→																														
	1100	→																														
	1700	→																														
Start Date: <u>10-7-05</u> Prescriber: <u>Thomas</u> Stop Date: <u>10-17-05</u> RX #:																																
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: Prescriber: Stop Date: RX #:																																
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: Prescriber: Stop Date: RX #:																																
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: Prescriber: Stop Date: RX #:																																
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: Prescriber: Stop Date: RX #:																																
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: Prescriber: Stop Date: RX #:																																
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: Prescriber: Stop Date: RX #:																																
Diagnosis	Nurse's Signature		Initial		Nurse's Signature		Initial		Documentation Codes																							
Allergies <u>NKA</u>	<u>[Signature]</u>		<u>ES</u>		<u>[Signature]</u>		<u>ES</u>		1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other																							
Housing Unit:																																
Patient ID Number: <u>175247</u>																																
Patient Name: <u>Palmer, Nelson</u>									Date of Birth:																							



Facility Name: <u>Bullock Correctional Facility</u>		Month/Y: <u>09/05</u>												Charting: <u>09/05</u>																					
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				
Fluphenazine HCl 10MG Tab 30.00																																			
Take 1 tablet(s) by mouth daily																																			
Start Date: <u>07-20-2005</u>		Prescriber: <u>Sanders MHM, William</u>																																	
Stop Date: <u>10-17-2005</u>		RX #: <u>250236731</u>																																	
Diphenhydramine HCl 50MG Cap 60.00																																			
Take 1 capsule(s) by mouth twice daily																																			
Start Date: <u>07-20-2005</u>		Prescriber: <u>Sanders MHM, William</u>																																	
Stop Date: <u>10-17-2005</u>		RX #: <u>250236753</u>																																	
<u>Cozart 2mg hs</u> <u>x 90d</u>																																			
Start Date: <u>9-8-05</u>		Prescriber: <u>W. Matthe</u>																																	
Stop Date: <u>12-5-05</u>		RX #: <u></u>																																	
Start Date: <u></u>		Prescriber: <u></u>																																	
Stop Date: <u></u>		RX #: <u></u>																																	
Start Date: <u></u>		Prescriber: <u></u>																																	
Stop Date: <u></u>		RX #: <u></u>																																	
Start Date: <u></u>		Prescriber: <u></u>																																	
Stop Date: <u></u>		RX #: <u></u>																																	
Diagnosis		Nurse's Signature										Initial		Nurse's Signature										Initial		Documentation Codes									
<u>Allergies: <u>None</u></u>		<u>V. Riggins</u>										<u>WR</u>		<u>Stacy L</u>										<u>SL</u>		1 Discontinued Order									
		<u>B. Riggins</u>										<u>BR</u>		<u>B. Smith</u>										<u>BS</u>		2 Refused									
		<u>B. Riggins</u>										<u>BR</u>		<u>B. Smith</u>										<u>BS</u>		3 Patient out of facility									
Housing Unit: <u>Population</u>																										4 Charted in Error									
Patient ID Number: <u>173247</u>																										5 Lock Down									
Patient Name: <u>Palmer, Nelson</u>																										6 Self Administered									
																										7 Medication out of Stock									
																										8 Medication Held									
																										9 No Show									
																										10 Other									

Facility Name: Bullock Correctional Facility										Month/Yr: Charting: 08/05																																	
Fluphenazine HCl 10MG Tab      30.00  Take 1 tablet(s) by mouth daily										Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
										Start Date: 07-20-2005															Prescriber: Sanders MHM, William																		
Stop Date: 10-17-2005															RX #: 250236731																												
Diphenhydramine HCl 50MG Cap 60.00  Take 1 capsule(s) by mouth twice daily										Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
										Start Date: 07-20-2005															Prescriber: Sanders MHM, William																		
Stop Date: 10-17-2005															RX #: 250236753																												
										Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
										Start Date:															Prescriber:																		
Stop Date:															RX #:																												
										Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
										Start Date:															Prescriber:																		
Stop Date:															RX #:																												
										Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
										Start Date:															Prescriber:																		
Stop Date:															RX #:																												
										Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
										Start Date:															Prescriber:																		
Stop Date:															RX #:																												
										Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
										Start Date:															Prescriber:																		
Stop Date:															RX #:																												
Diagnosis										Nurse's Signature										Initial		Nurse's Signature										Initial		Documentation Codes									
Allergies hRA										V. Riggins										VR		Bennett										BP		1 Discontinued Order									
Housing Unit: Population										S. Anderson										SA		L. Brown										LB		2 Refused									
Patient ID Number: 173247										J. Haices										JH														3 Patient out of facility									
Patient Name: Palmer, Nelson																																		4 Charted in Error									
																																		5 Lock Down									
																																		6 Self Administered									
																																		7 Medication out of Stock									
																																		8 Medication Held									
																																		9 No Show									
																																		10 Other									



Facility Name:

*Prolixin Dec 25mg  
IM Q 3 wks  
X-90 days*

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: *7-18-05*

Prescriber:

Stop Date: *10-18-05*

RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date:

Prescriber:

Stop Date:

RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date:

Prescriber:

Stop Date:

RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date:

Prescriber:

Stop Date:

RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date:

Prescriber:

Stop Date:

RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date:

Prescriber:

Stop Date:

RX #:

Diagnosis

Nurse's Signature

Initial

Nurse's Signature

Initial

Documentation Codes

Allergies

*A. Thomas* *AT*  
*J. H. H.* *B*

Housing Unit:

Patient ID Number:

Patient Name:

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

*Palmer - Nelson*

Date of Birth:



MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	
Polixin Dec 25mg IM Q3wks		0700																													
Start 7-18-05 Stop 10-18-05			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	

CHARTING FOR			7-18-05 THROUGH 7-31-05		
Physician			Telephone No.		Medical Record No.
Alt. Physician			Alt. Telephone		
Allergies			Rehabilitative Potential		

Diagnosis				
Medicaid Number	Medicare Number	Complete Entries Checked:		
PATIENT	By: <i>L. Rapp</i>	Title: <i>on</i>	Date: <i>7-1</i>	
<i>PALMER, Nelson</i>	PATIENT CODE	ROOM NO.	BED	FACIL



## MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Selam Sbringer Top. qd x 90d 6/22/5 — 9-22-5	K Op.																												
Hydrocodone 0.5g Top. Bid Prn X 30d 6/22/5 — 7-22-5	K Op.																												
Prolixin 10mg po qhs x 90d 6/21/5 — 9/21/5	2000																												
Dibazolyl 50g po qhs x 90d 6/21/5 — 9/21/5	2000																												
Prolixin Dec. 25g Im q 3wk X 80d 6/22/5 — 9/22/5	1 +																												
Prolixin 10mg po qd x 90days Start 7-18-05 Stop 10-18-05	Sander 1700																												
Prolixin Decorate 25mg Imk q3wks x 90days Start 7-18-05 Stop 10-18-05	Sander 0730																												
Benzodol 50mg po Bid x 90days Start 7-18-05 Stop 10-18-05	Sander 1100																												
	Sander 1700																												

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																													
CHARTING FOR 7-1-05		THROUGH 7-31-5																											
Physician														Telephone No.															
Alt. Physician														Alt. Telephone															
Regies														Rehabilitative Potential															
Medical Record N														17324															
Diagnosis																													
Medicaid Number								Medicare Number								Complete Entries Checked													
PATIENT								By: [Signature]								Title: [Signature]								Date: 7/1					
Palmer, Nelson								PATIENT CODE								ROOM NO.								BED					



II

[illegible]



I & II

[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE.

CHARTING FOR 6/22/05 THROUGH 6/30/05

Physician	Telephone No	Medical Record <b>17324</b>
Alt Physician <i>Adelma Clark</i>	Alt Telephone	

<p>Arguments</p> <p><i>NICBA</i></p>	<p>Rehabilitative Potential</p>
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Diagnosis	
-----------	--

Medicaid Number	Medicare Number	Complete Entries Checked:
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By: <i>H. P. Krayn</i>		Title: <i>RN</i>		Date: <i>6/9</i>	
PATIENT	<i>7</i>	PATIENT CODE	ROOM NO.	BED	FAC

Palmer, Nelson	173247	k
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03/27/2006 MON 16:04 FAX

001/001

03/27/2006 14:04 FAX 0344

# MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print  
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS	
<p>Site Name &amp; Number:</p> <p><b>BULLOCK 832</b></p> <p>Site Phone #</p> <p><b>(334) 738-5625</b></p> <p>Site Fax #</p> <p><b>(334) 738-8752</b></p> <p>Will there be a charge? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>Patient Name: (Last, First)</p> <p><b>Palmer Nelson</b></p> <p>Address: (Last, First)</p> <p><b>173247</b></p> <p>SS Number</p> <p><b>[REDACTED]</b></p> <p>Date: (mm/dd/yy)</p> <p><b>2.3.17.06</b></p> <p>Date of Birth: (mm/dd/yy)</p> <p><b>[REDACTED]</b></p> <p>PHS Custody Date: (mm/dd/yy)</p> <p><b>2.6.8.05</b></p> <p>Potential Release Date: (mm/dd/yy)</p> <p><b>2.7.8.08</b></p>
<p>Responsible party: <input checked="" type="checkbox"/> PHS <input type="checkbox"/> Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans) <input type="checkbox"/> Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services)</p> <p><input type="checkbox"/> ALIA Inc.</p>	
CLINICAL DATA	
<p>Requesting Provider: <input checked="" type="checkbox"/> Physician <input type="checkbox"/> NP, PA <input type="checkbox"/> Dentist</p> <p>Facility Medical Director Signature and Date:</p> <p><b>[Signature]</b></p> <p><input type="checkbox"/> Service meets criteria for "approval via protocol"</p> <p>Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.</p> <p><input type="checkbox"/> Office Visit (OV) <input type="checkbox"/> X-ray (XR) <input type="checkbox"/> Scheduled Admission (SA)</p> <p><input checked="" type="checkbox"/> Outpatient Surgery (OS) <input type="checkbox"/> Dialysis (DA)</p> <p><input type="checkbox"/> Routine <input type="checkbox"/> Urgent</p> <p>Estimated Date of Service (mm/dd/yy): <b>2.3.17.06</b></p> <p>(This starts the approval window for the "open authorization period")</p> <p>Multiple Visits/Treatments: <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other</p> <p>Number of Visits/Treatments: <b>3</b></p> <p>Specialist referred to: <b>Dr. White-Badst</b></p> <p>Type of Consultation, Treatment, Procedure or Surgery:</p> <p><b>Excision By Dr. White</b></p> <p>Diagnosis: <b>Mass Clipping</b></p> <p>ICD-9 code: <b>[REDACTED]</b></p> <p>You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.</p> <p><input type="checkbox"/> Pertinent Documents have been attached and faxed.</p>	<p>History of Illness/Injury/Symptoms with Date of Onset:</p> <p><b>met a large mass to the back of his neck</b></p> <p>Results of a complaint directed physical examination:</p> <p><b>Big Mass / upon a fiddle. 6x6 inches</b></p> <p>Previous treatment and response (including medications):</p> <p><b>Asup</b></p> <p><b>One Refusion RNHSA 3/17/06</b></p> <p>***For security and safety, please do not inform patient of possible follow-up appointments***</p>
<p>UN DETERMINATION:</p> <p><input type="checkbox"/> Alternative Treatment Plan (explain here):</p> <p><input type="checkbox"/> More Information Requested (See Attached)</p> <p><input type="checkbox"/> Resubmitted with requested information.</p> <p>Regional Medical Director Signature, printed name and date required:</p> <p><b>[Signature]</b> <b>3.20.06</b></p> <p>Do not write below this line. For Case Manager and Corporate Data Entry ONLY.</p> <p>Case Type: <b>[REDACTED]</b> Med Class: <b>[REDACTED]</b> CPT code: <b>[REDACTED]</b> UR Auth: <b>[REDACTED]</b></p>	

Call Dr. McQueen 3/27/06 This is not Elective. He has HUGE Mass which is interfering to lay down, sleep, and hurls. His dimensions are about 6x9 inches and is escaping the net.

FAXED MAR 27 2006



**REGIONAL OFFICE BULLOCK**

**001/001**

**PHS**

**VIEW FORM**

**DEMOCRAPHICS**

**Site Name & Number:** BULLOCK 832

**Site Phone #** (334) 738-5625

**Site Fax #** (334) 738-8763

**Will there be a charge?** ☒ Yes ☐ No

**Sex** ☒ Male ☐ Female

**Patient Name: (Last, First)** Palmer Nelson

**Date: (mm/dd/yy)** 03/17/06

**Alia: (Last, First)**

**Date of Birth: (mm/dd/yy)**

**Inmate #** 173247

**PHS Custody Date: (mm/dd/yy)** 06/28/05

**SS Number**

**Potential Release Date: (mm/dd/yy)** 07/29/08

**Responsible party:** ☒ PHS ☐ Auto Ins. ☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

**Requesting Provider:** ☒ Physician ☐ NP, PA ☐ Dental

**Facility Medical Director Signature and Date:**

☐ Service meets criteria for "approval via protocol"

**Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.**

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☒ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

**Estimated Date of Service (mm/dd/yy)**

**Multiple Visits/Treatments:** ☐ Radiation therapy ☐ Chemotherapy ☐ Other:

**Number of Visits/Treatments:**

**Specialist referred to:** Dr. Whyte-Baptist

**Type of Consultation, Treatment, Procedure or Surgery:** Excision By Dr. Whyte

**Diagnosis:** mass lipoma

**ICD-9 code:**

**You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.**

☐ Pertinent Documents have been attached and faxed.

**History of Illness/Injury/symptoms with Date of Onset**

Inmate i Huge Mass to the Back of his neck

**Results of a complaint directed physical examination:**

Big Mass / lipoma 6x6 inches

**Previous treatment and response (including medications):**

Adip

**Due Pleinon RNH8A 3/17/06**

**\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\***

**UM DETERMINATION:** ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

**Regional Medical Director Signature, printed name and date required:**

**Do not write below this line. For Case Manager and Corporate Data Entry ONLY.**

**Cent Type:** Med Class: **CPT code:** **UR Auth #:**

05a - UM Referral review form

This is not Elective. He has HUGE Mass which is interfering to lay down, sleep, and hurls. Ns

## UTILIZATION MANAGEMENT REFERRAL REF 'IEW FORM

must be Complete and Legible. You must Type c

Please send this form. the Authorization Letter to the service provider at time of the Appointment

PHS

## DEMOGRAPHICS

Site Name &amp; Number:

BULLOCK 832

Patient Name: (Last, First)

Palmer Nelson

Date: (mm/dd/yy)

03/17/06

Site Phone #

(334) 738-5625

Alias: (Last, First)

Date of Birth: (mm/dd/yy)

[REDACTED]

Site Fax #

(334) 738-8763

Inmate #

173247

PHS Custody Date: (mm/dd/yy)

06/22/05

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

SS Number

[REDACTED]

Potential Release Date: (mm/dd/yy)

07/29/08

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☒ Physician☐ NP, PA☐ Dental

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☒ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

\_\_\_/\_\_\_/\_\_\_

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments: \_\_\_\_\_

☐ Other: \_\_\_\_\_

Specialist referred to:

Dr. Whyte-Baptist

Type of Consultation, Treatment, Procedure or Surgery:

Excision By Dr. Whyte

Diagnosis:

ICD-9 code:

mass lipoma

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

Inmate i huge mass to the back of his neck

Results of a complaint directed physical examination:

Big Mass / lipoma  
fused  
6x6 inches

Previous treatment and response (including medications):

Adip

Dore Polunin RN/HSA 3/17/06

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.

Date resubmitted:

\_\_\_/\_\_\_/\_\_\_

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:

**PRISON HEALTH SERVICES: AUTHORIZATION LETTER**

<b>Patient Name:</b>	Palmer, Nelson	<b>Inmate Number:</b>	173247PA
<b>Service Authorized:</b>	X-Ray: Ct Scan	<b>Effective Dates:</b>	01/23/2006
<b>Effective:</b>	Visits authorized for 60 days from effective date.	<b>Visits Authorized:</b>	1
<b>Responsible Facility:</b>	Bullock Correctional Facility	<b>Contact Name:</b>	Michelle Pope
<b>Authorization Number:</b>	15785952	<b>Telephone Number:</b>	(334)395-5973 Ext 14

**Note to Provider of Services:**

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

**For Payment Please Submit Claims To:**

Prison Health Services  
P.O. Box 967  
Brentwood, TN 37024-0967

**The consulting physician should complete this section.  
The completed form will be sealed in the attached envelope and  
returned with an officer to the correctional facility.**

**Clinical Summary or Attached Report**

**\*\*\* For security and safety, please do not inform patient of possible follow-up appointments. \*\*\***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By  
Medical Director:

Date

Time

Bullock County Hospital  
102 W Conecuh  
Union Springs, AL  
228-2140

## UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

This form must be Complete and Legible. You must Type or Print.

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

## DEMOGRAPHICS

Site Name &amp; Number:

Bullock 832

Site Phone #

(334) 738-5625

Site Fax #

(334) 738-8763

Patient Name: (Last, First)

Nelson, Palmer

Date: (mm/dd/yy)

06.23.06

Alias: (Last, First)

Date of Birth: (mm/dd/yy)

[REDACTED]

Inmate #

173247

PHS Custody Date: (mm/dd/yy)

06.22.05

SS Number

[REDACTED]

Potential Release Date: (mm/dd/yy)

07.29.08

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☒ Physician☐ NP, PA☐ Dental

Facility Medical Director Signature and Date:

[Signature]

☐ Service meets criteria for approval via protocol

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)☒ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

\_\_\_/\_\_\_/\_\_\_

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments: \_\_\_\_\_

☐ Other: \_\_\_\_\_

Specialist referred to:

Bullock County Hospital

Type of Consultation, Treatment, Procedure or Surgery:

CT Scan of chest neck

Diagnosis:

ICD-9 code:

GROWTH to neck/chest

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

Inmate was huge smelling to the posterior chest wall. He was seen by wife, who wants CT

Results of a complaint directed physical examination:

Scan of the neck/chest to delineate the extent of growth

Previous treatment and response (including medications):

[Signature]

A. Groom RN D.O.N.

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.

Date resubmitted:

\_\_\_/\_\_\_/\_\_\_

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:



&lt;&lt; Back Print



## STATE OF ALABAMA INMATE HEALTHCARE AUTHORIZATION

Enrollment  
Telephone (334) 833-5948  
Toll Free (866) 853-1384  
Fax (334) 240-1488

Blue Cross Blue Shield of Alabama  
(877) 231-7239

Prison Health Services  
Telephone (334) 395-5973  
Toll Free (877) 279-1335  
Fax (334) 395-8156

1/26/2006

Inmate Name	PALMER, NELSON	Inmate #	00173247
Facility Name	BULLOCK CORRECTIONAL FACILITY		
Facility Address1	POB 5107		
Facility Address2			
City	UNION SPRINGS		
State	AL		
Zipcode	36089		

**\* Attention Health Care Provider \***

### For Hospital/Facility Claims:

All facility claims for inpatient and outpatient services should be submitted directly to Blue Cross and Blue Shield of Alabama. Please submit your facility charges to Blue Cross under group **57688** with contract number **XAJ624632213** as you currently do for all other Blue Cross subscribers. This process applies to facility charges only and does not include physician services.

### Utilization Management Review:

All concurrent in-patient reviews must be provided to PHS Regional Office in Montgomery. The contact person is Michelle Pope, Utilization Management Coordinator. (334) 395-5973 Ext 14

### For charges not covered under SEIB - BC/BS Program:

For Payment, Please Submit Claims with Inmate number to:  
Prison Health Services  
P.O.Box 967  
Brentwood TN 37024-0967

- Medicare/Medicaid does not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number).
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until a clinical summary is received.

# UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

## DEMOGRAPHICS

Site Name & Number:

Bullock 832

Site Phone #

(334) 738-5625

Site Fax #

(334) 738-8763

Patient Name: (Last, First)

Nelson, Palmer

Alias: (Last, First)

Inmate #

173247

SS Number

Date: (mm/dd/yy)

06/23/06

Date of Birth: (mm/dd/yy)

PHS Custody Date: (mm/dd/yy)

06/23/05

Potential Release Date: (mm/dd/yy)

07/29/08

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS

☐ Auto Ins.

☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)

☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☒ Physician

☐ NP, PA

☐ Dental

Facility Medical Director Signature and Date:

☐ Service meets criteria for approval via protocol

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)

☒ X-ray (XR)

☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS)

☐ Dialysis (DA)

☐ Routine

☐ Urgent

Estimated Date of Service (mm/dd/yy)

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy

☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

Bullock County Hospital

Type of Consultation, Treatment, Procedure or Surgery:

CT Scan of chest neck

Diagnosis:

ICD-9 code:

Growth to neck/chest

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and filed.

History of illness/injury/symptoms with Date of Onset:

Inmate has large swelling to the posterior chest wall. He was seen by wife, who wants CT

Results of a complaint directed physical examination:

Scan of the neck/chest to delineate the extent of growth

Previous treatment and response (including medications):

Adel

A. Groom RN D.O.N.

For security and safety, please do not inform patient of possible follow-up appointments.

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☒ Official Service Recommended and Authorized

Date resubmitted:

Regional Medical Director Signature, printed name and date required:

0124046

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Code Type:

CT

Mod Class:

XR

CPT code:

71275

70492

UR Auth #:

15785952

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**PRISON HEALTH SERVICES: AUTHORIZATION LETTER**

<b>Patient Name:</b>	Palmer, Nelson	<b>Inmate Number:</b>	173247PA
<b>Service Authorized:</b>	X-Ray: Ct Scan	<b>Effective Dates:</b>	01/23/2006
<b>Effective:</b>	Visits authorized for 60 days from effective date.	<b>Visits Authorized:</b>	1
<b>Responsible Facility:</b>	Bullock Correctional Facility	<b>Contact Name:</b>	Michelle Pope
<b>Authorization Number:</b>	15785952	<b>Telephone Number:</b>	(334)395-5973 Ext 14

**Note to Provider of Services:**

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
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- Payment will not be processed until we receive a clinical summary.

**For Payment Please Submit Claims To:**

Prison Health Services  
P.O. Box 967  
Brentwood, TN 37024-0967

**The consulting physician should complete this section.  
The completed form will be sealed in the attached envelope and  
returned with an officer to the correctional facility.**

**Clinical Summary or Attached Report**

**\*\*\* For security and safety, please do not inform patient of possible follow-up appointments. \*\*\***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By  
Medical Director:

Date

Time

*Bullock County Hospital  
Hwy 88 East  
Union Springs, AL  
738-2140*



## UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print.  
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

## DEMOGRAPHICS

Site Name &amp; Number:

Bullock 832

Site Phone #

(334) 738-5625

Site Fax #

(334) 738-8763

Patient Name: (Last, First)

Nelson, Palmer

Alias: (Last, First)

Inmate #

173247

SS Number

Date: (mm/dd/yy)

06.23.06

Date of Birth: (mm/dd/yy)

PHS Custody Date: (mm/dd/yy)

06.22.05

Potential Release Date: (mm/dd/yy)

07.29.08

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☒ Physician☐ NP, PA☐ Dental

Facility Medical Director Signature and Date:

[Signature]

☐ Service meets criteria for approval via protocol

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)☒ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

\_\_\_/\_\_\_/\_\_\_

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments: \_\_\_

☐ Other: \_\_\_

Specialist referred to:

Bullock County Hospital

Type of Consultation, Treatment, Procedure or Surgery:

CT Scan of chest &amp; neck

Diagnosis:

ICD-9 code:

GROWTH to neck/chest

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

Inmate was huge  
smelling to the posterior chest  
wall. He was seen by  
white, who wants CT  
Scan of the neck/chest  
to delineate the extent  
of growth

Results of a complaint directed physical examination:

Scan of the neck/chest  
to delineate the extent  
of growth

Previous treatment and response (including medications):

[Signature]

A. Groom W.D.O.W.

\*\*\*For security and safety, please do not inform patient of  
possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.☐ Offsite Service Recommended and Authorized

Date resubmitted:

\_\_\_/\_\_\_/\_\_\_

Regional Medical Director Signature,  
printed name and date required:

(mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:

<< Back Print



## STATE OF ALABAMA INMATE HEALTHCARE AUTHORIZATION

Enrollment  
Telephone (334) 833-5948  
Toll Free (866) 853-1384  
Fax (334) 240-1488

Blue Cross Blue Shield of Alabama  
(877) 231-7239

Prison Health Services  
Telephone (334) 395-5973  
Toll Free (877) 279-1335  
Fax (334) 395-8156

1/26/2006

Inmate Name	PALMER, NELSON	Inmate #	00173247
Facility Name	BULLOCK CORRECTIONAL FACILITY		
Facility Address1	POB 5107		
Facility Address2			
City	UNION SPRINGS		
State	AL		
Zipcode	36089		

**\* Attention Health Care Provider \***

### For Hospital/Facility Claims:

All facility claims for inpatient and outpatient services should be submitted directly to Blue Cross and Blue Shield of Alabama. Please submit your facility charges to Blue Cross under group **57688** with contract number **XAJ624632213** as you currently do for all other Blue Cross subscribers. This process applies to facility charges only and does not include physician services.

### Utilization Management Review:

All concurrent in-patient reviews must be provided to PHS Regional Office in Montgomery. The contact person is Michelle Pope, Utilization Management Coordinator. (334) 395-5973 Ext 14

### For charges not covered under SEIB - BC/BS Program:

For Payment, Please Submit Claims with Inmate number to:  
Prison Health Services  
P.O.Box 967  
Brentwood TN 37024-0967

- Medicare/Medicaid does not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number).
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until a clinical summary is received.

## PRISON HEALTH SERVICES: AUTHORIZATION LETTER

<b>Patient Name:</b>	Palmer, Nelson	<b>Inmate Number:</b>	173247PA
<b>Service Authorized:</b>	Office Visits: General Surgery Consult	<b>Effective Dates:</b>	09/27/2005
<b>Effective:</b>	Visits authorized for 60 days from effective date.	<b>Visits Authorized:</b>	1
<b>Responsible Facility:</b>	Bullock Correctional Facility	<b>Contact Name:</b>	Michelle Pope
<b>Authorization Number:</b>	15473182	<b>Telephone Number:</b>	(334)395-5973 Ext 14

## Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services  
P.O. Box 967  
Brentwood, TN 37024-0967

The consulting physician should complete this section.  
The completed form will be sealed in the attached envelope and  
returned with an officer to the correctional facility.

## Clinical Summary or Attached Report

IMPRESSION: ENLARGING POSTERIOR NOSE MASS, POSSIBLE ULCER

PLAN: (1) NEEDS MRI TO EVALUATE ORIGIN

AND DEPTH OF MASS.

(1) WILL HAVE FURTHER RECOMMENDATIONS  
AFTER THAT.

\*\*\* For security and safety, please do not inform patient of possible follow-up appointments. \*\*\*

Signature of Consulting Physician:

Dr. Whyte

Date

10/18/05

Time

Reviewed and Signed By  
Medical Director:

Date

Time

Dr. Whyte  
337 St Luke Drive  
Montgomery, AL  
271-2788-10-10<sup>15</sup>



**PRISON HEALTH SERVICES: AUTHORIZATION LETTER**

<b>Patient Name:</b>	Palmer, Nelson	<b>Inmate Number:</b>	173247PA
<b>Service Authorized:</b>	Office Visits: General Surgery Consult	<b>Effective Dates:</b>	09/27/2005
<b>Effective:</b>	Visits authorized for 60 days from effective date.	<b>Visits Authorized:</b>	1
<b>Responsible Facility:</b>	Bullock Correctional Facility	<b>Contact Name:</b>	Michelle Pope
<b>Authorization Number:</b>	15473182	<b>Telephone Number:</b>	(334)395-5973 Ext 14

**Note to Provider of Services:**

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

**For Payment Please Submit Claims To:**

Prison Health Services  
P.O. Box 967  
Brentwood, TN 37024-0967

**The consulting physician should complete this section.  
The completed form will be sealed in the attached envelope and  
returned with an officer to the correctional facility.**

**Clinical Summary or Attached Report**

**\*\*\* For security and safety, please do not inform patient of possible follow-up appointments. \*\*\***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By  
Medical Director:

Date

Time

Dr. Whyte  
337 St Luke Drive  
Montgomery, AL  
271-2788 + 11/15

09/29/2005

## UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PMS

## DEMOGRAPHICS

Site Name &amp; Number:

Bullock 832

Site Phone #

334, 738, 5625

Site Fax #

334, 738, 8763

Patient Name: (Last, First)

Palmer, Nelson

Alias: (Last, First)

Inmate #

173247

SS Number

Date: (mm/dd/yy)

09.27.05

Date of Birth: (mm/dd/yy)

PMS Custody Date: (mm/dd/yy)

06.22.05

Potential Release Date: (mm/dd/yy)

03.07.06

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☐ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☒ Physician☐ NP, PA☐ Dental

Facility Medical Director Signature and Date:

[Signature] 9/26/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

/ /

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

Dr. White

Type of Consultation, Treatment, Procedure or Surgery:

Huge Lipoma

Diagnosis:

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

HUGE lipoma to the back of neck. It was small 2 yrs ago.

Results of a complaint directed physical examination:

ago. It is short obliterating the neck and he has difficulty sleeping & extending

Previous treatment and response (including medications):

this neck. 6 x 8 inches & getting bigger

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.

Date resubmitted:

/ /

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:

09/28/2005 09:06 FAX 3343958156

REGIONAL OFFICE

+ DONALDSON

2090

### UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PATIENT NAME & NUMBER			PATIENT NAME (Last, First)			DATE (mm/dd/yyyy)		
Bullock 832			Palmer, Nelson			09.18.05		
SAY PHONE #			ALLER (Last, First)			DATE OF BIRTH (mm/dd/yyyy)		
B341738-5625								
SAY FAX #			HMO #			PHS CUSTODY DATE (mm/dd/yyyy)		
(334) 738-8763			173247			06.18.05		
Will there be a change?			SS NUMBER			Potential Release Date (mm/dd/yyyy)		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						03.07.06		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Responsible party:			Health Ins. (Includes Medicare/Medicaid Managed Care Alternative plans)					
<input type="checkbox"/> HHS <input type="checkbox"/> Auto Inc.			<input type="checkbox"/> Other, be specific (Includes Medicare, Medicaid and Veterans Administration Security)					
CLINICAL DATA								
Referring Physician			History of Illness/Surgery/Injury with Date of Onset:					
Facility Medical Director Signature and Title			Huge Epoma to the back of neck. It was small 2 yrs ago. It is short obliterating the neck and he has difficulty sleeping & extending					
<input type="checkbox"/> Service needs referral for approval to submit			Results of a complaint directed physical examination:					
Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.			Chronic Illness (PM) <input type="checkbox"/> X-ray (PM) <input type="checkbox"/> Scheduled Admission (PM) <input type="checkbox"/> Outpatient Surgery (PM) <input type="checkbox"/> Inpatient (PM) <input type="checkbox"/> Urgent <input type="checkbox"/> Urgent			6 x 8 inches & getting bigger		
Estimated Date of Service (mm/dd/yyyy)			Multiple Visits/Treatments:					
			<input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other					
(This starts the approval window for the "appt" authorization period)			Number of Visits/Treatments:					
			Specimens referred for:					
Type of Consultation, Treatment, Procedure or Surgery:			Diagnosis:					
Huge Epoma			Dr. White 214					
You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.			For security and safety, please do not inform patient of possible follow-up appointments					
<input type="checkbox"/> Pertinent Documents have been attached and listed.			UNI DETERMINATION:					
<input type="checkbox"/> Alternative Treatment Plan (explain here):			<input type="checkbox"/> Outpatient Services Recommended and Authorized					
<input type="checkbox"/> More Information Requested (See Remarks):								
<input type="checkbox"/> Referred with required information								
Regional Medical Director Signature:			Do Not write below this line. For Case Manager and Corporate Case Entry ONLY.					
Printed name and date required:			Case number:					
Will Mosler, MD			9.29.05					
Case Type:			Mod Case:					
GS			OV					
OPT code:			49201					
UR Auth #:			15473182					

03a - UM Referral review form.doc



Patient Name: *Robert Palmer*  
 Age: 37 M, F  
 5/11/2018  
 173247

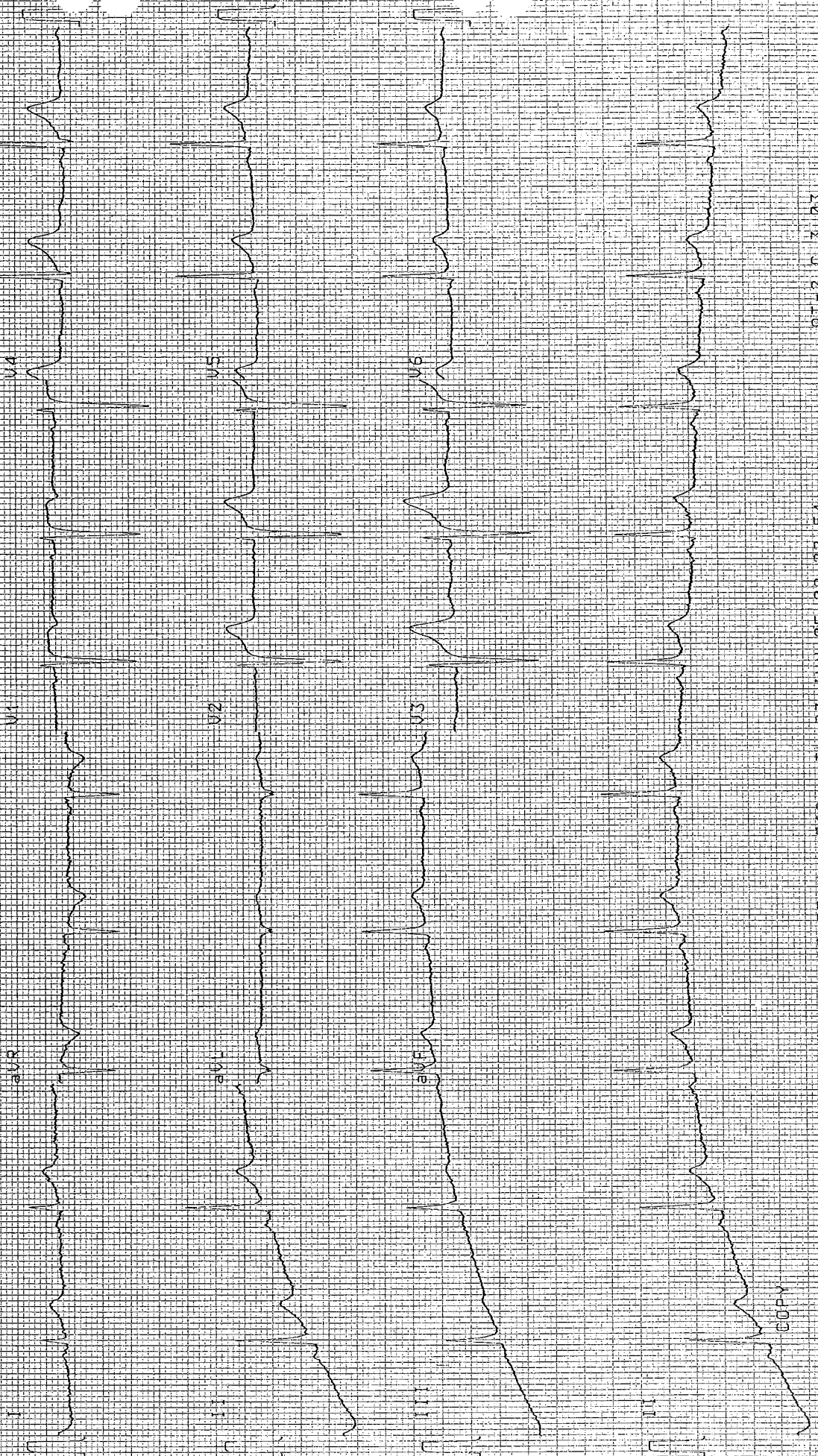
HR: 64 BPM  
 Rhythm: SINUS RHYTHM  
 PR: 142 ms  
 QRS: 90 ms  
 QT: 366 ms  
 QTc: 375 ms

PR: 142 ms  
 QRS: 90 ms  
 QT: 366 ms  
 QTc: 375 ms

UNCONFIRMED REPORT

10 mm/mV

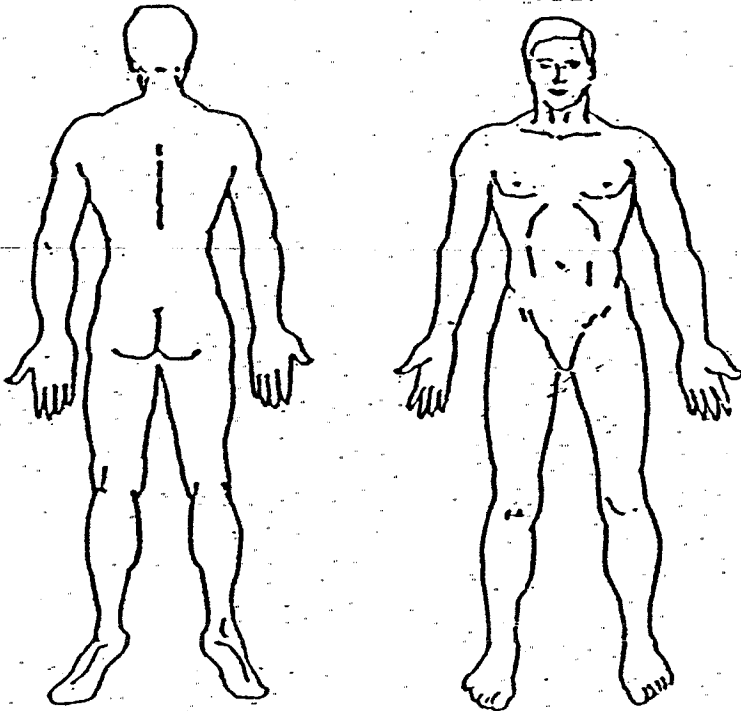
10 mm/mV



### TREATMENT REQUEST AND RECORD

# EKG

AREA OF TREATMENT (CIRCLE)



**PROGRESS NOTES:**

[illegible]

10 A

Nelson

37

 $\beta/m$ 

173





LabCorp Montgomery Hull  
543 Hull Street, Montgomery, AL 36104-0000



Phone: 334-263-5745

<b>SPECIMEN</b> 173-684-3104-0	<b>TYPE</b> S	<b>PRIMARY LAB</b> YX	<b>REPORT STATUS</b> COMPLETE	<b>Page #:</b> 1
<b>ADDITIONAL INFORMATION</b>				
NPY-3		FASTING: N DOB: [REDACTED]		
<b>PATIENT NAME</b> PALMER, NELSON		<b>SEX</b> M	<b>AGE(YR./MOS.)</b> 47 / 2	
<b>PT. ADD.:</b>				
<b>DATE OF SPECIMEN</b> 6/22/2005	<b>TIME</b> 6:00	<b>DATE RECEIVED</b> 6/22/2005	<b>DATE REPORTED</b> 6/22/2005	<b>TIME</b> 15:19 7607

<b>CLINICAL INFORMATION</b>	
CD- 41139318288	
<b>PHYSICIAN ID.</b> ROBBINS M	<b>PATIENT ID.</b> 173247
<b>ACCOUNT:</b> Kilby Correctional Facility Prison Health Services PO BOX 11 Mt Meigs AL 36057-0000	
<b>ACCOUNT NUMBER:</b> 01306900	

TEST	RESULT	LIMITS	LAB
CBC With Differential/Platelet			
White Blood Cell (WBC) Count	6.4 x10E3/uL	4.0 - 10.5	YX
> Red Blood Cell (RBC) Count	5.64H x10E6/uL	4.10 - 5.60	YX
Hemoglobin	16.5 g/dL	12.5 - 17.0	YX
> Hematocrit	51.0H %	36.0 - 50.0	YX
MCV	90 fL	80 - 98	YX
MCH	29.1 pg	27.0 - 34.0	YX
MCHC	32.3 g/dL	32.0 - 36.0	YX
RDW	12.9 %	11.7 - 15.0	YX
Platelets	250 x10E3/uL	140 - 415	YX
Neutrophils	59 %	40 - 74	YX
Lymphs	31 %	14 - 46	YX
Monocytes	7 %	4 - 13	YX
Eos	2 %	0 - 7	YX
Basos	1 %	0 - 3	YX
Neutrophils (Absolute)	3.8 x10E3/uL	1.8 - 7.8	YX
Lymphs (Absolute)	2.0 x10E3/uL	0.7 - 4.5	YX
Monocytes (Absolute)	0.4 x10E3/uL	0.1 - 1.0	YX
Eos (Absolute)	0.1 x10E3/uL	0.0 - 0.4	YX
Baso (Absolute)	0.1 x10E3/uL	0.0 - 0.2	YX

LAB: YX LabCorp Montgomery Hull  
543 Hull Street, Montgomery, AL 36104-0000

DIRECTOR: Alton Sturtevant B PhD

Pat Name: PALMER, NELSON

Pat ID: 173247

Spec #: 173-684-3104-0

Seq #: 7607

Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report





KILBY CORRECTIONAL FACILITY  
PO BOX 11  
MT. MEIGS, AL 36057

DATE OF REPORT: 6/24/2005  
TIME OF REPORT: 7:23 AM

<i>AIS NO.</i> <b>NPY3/173247</b>	<i>NAME</i> <b>NELSON PALMER</b>	<i>FACILITY</i> <b>Kilby</b>
--------------------------------------	-------------------------------------	---------------------------------

<i>DATE COLLECTED</i> <b>6/22/05</b>	<i>TIME COLLECTED</i> <b>8:30 AM</b>
---	---

<i>DATE RECEIVED</i> <b>6/21/05</b>	<i>TIME RECEIVED</i> <b>4:13 PM</b>
--	--

<b>Test Name</b>	<b>Result</b>	<b>Out of Range</b>	<b>Reference Range</b>
HIV ANTIBODY	NEG		NEGATIVE (NEG)
RPR	NR		NON-REACTIVE (NR)
<b>URINALYSIS</b>			
PROTEIN	NEG		NEGATIVE (NEG)
GLUCOSE	NEG		NEGATIVE (NEG)
KETONES	NEG		NEGATIVE (NEG)
BILIRUBIN	NEG		NEGATIVE (NEG)
BLOOD	NEG		< 5 RBC/MCL (NEG)
NITRITE	NEG		NEGATIVE (NEG)
UROBILINOGEN	NEG		< 1.0 MG/DL (NEG)
LEUK. ESTERASE	NEG		NEGATIVE (NEG)

\* NT = Not Tested





LabCorp Montgomery Hull  
543 Hull Street, Montgomery, AL 36104-0000



Phone: 334-263-5745

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
174-684-3114-0	S	YX	COMPLETE	1

#### ADDITIONAL INFORMATION

PHY-3  
6/22

FASTING: N  
DOB: [REDACTED]

PATIENT NAME  
**PALMER, NELSON**

SEX  
M

AGE(YR./MOS.)  
47 / 2

PT. ADD.:

#### CLINICAL INFORMATION

CD- 41139318398

PHYSICIAN ID.  
ROBBINS M

PATIENT ID.  
173247

ACCOUNT: Kilby Correctional Facility  
Prison Health Services  
12201 Wares Ferry Road  
Mt. Meigs AL 36507-0000  
ACCOUNT NUMBER: 01306900

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME	
6/23/2005	7:02	6/23/2005	6/23/2005	20:05	7683

TEST	RESULT	LIMITS	LAB
CMP14+LP+5AC			
Chemistries			YX
> Glucose, Serum	142 H mg/dL	65 - 99	YX
Uric Acid, Serum	5.9 mg/dL	2.4 - 8.2	YX
BUN	9 mg/dL	5 - 26	YX
Creatinine, Serum	1.2 mg/dL	0.5 - 1.5	YX
BUN/Creatinine Ratio	8	8 - 27	
Sodium, Serum	140 mmol/L	135 - 148	YX
Potassium, Serum	4.2 mmol/L	3.5 - 5.5	YX
Chloride, Serum	102 mmol/L	96 - 109	YX
Carbon Dioxide, Total	26 mmol/L	20 - 32	YX
Calcium, Serum	9.8 mg/dL	8.5 - 10.6	YX
Phosphorus, Serum	3.7 mg/dL	2.5 - 4.5	YX
Protein, Total, Serum	8.4 g/dL	6.0 - 8.5	YX
Albumin, Serum	4.6 g/dL	3.5 - 5.5	YX
Globulin, Total	3.8 g/dL	1.5 - 4.5	
A/G Ratio	1.2	1.1 - 2.5	
Bilirubin, Total	1.0 mg/dL	0.1 - 1.2	YX
Alkaline Phosphatase, Serum	71 IU/L	25 - 150	YX
> LDH	326 H IU/L	100 - 250	YX
AST (SGOT)	25 IU/L	0 - 40	YX
ALT (SGPT)	30 IU/L	0 - 40	YX
***EFFECTIVE JUNE 27, 2005, the reference intervals***			
will be changing to:			
Male 0 - 55 IU/L			
Female 0 - 40 IU/L			
> GGT	72 H IU/L	0 - 65	YX
Iron, Serum	154 ug/dL	40 - 155	YX
Lipids			YX
Cholesterol, Total	180 mg/dL	100 - 199	YX
> Triglycerides	195 H mg/dL	0 - 149	YX
HDL Cholesterol	54 mg/dL	40 - 59	YX
VLDL Cholesterol Calc	39 mg/dL	5 - 40	
LDL Cholesterol Calc	87 mg/dL	0 - 99	
T. Chol/HDL Ratio	3.3 ratio units	0.0 - 5.0	
Estimated CHD Risk	< 0.5 times avg.	0.0 - 1.0	
T. Chol/HDL Ratio			
Men Women			
1/2 Avg. Risk 3.4 3.3			
Avg. Risk 5.0 4.4			
Pat Name: PALMER, NELSON	Pat ID: 173247	Spec #: 174-684-3114-0	Seq #: 7683

Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page

